Talk It Out

New Client Intake Form

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| **Personal Details** |  |
| Name |  |
| Date Of Birth |  |
| Address |  |
| Email  |  |
| Mobile |  |
| GP Practice |  |
| **Medical History** | Please indicate any conditions you currently have or have had in the past. |
| Asthma |  |
| Diabetes |  |
| Cancer |  |
| Arthritis |  |
| Anxiety |  |
| Depression |  |
| PTSD |  |
| Other health Conditions |  |
| Medication (current) |  |
| Allergies |  |

**Consent**

|  |
| --- |
| I consent for my practitioner to collect, store and utilise this information for the purposes of providing services to me in accordance with the relevant privacy legislation and any other legal requirements that may apply. |
| Signed |
| Date |